EXHIBIT 7

VALLEY MEDICAL CENTER
RENTON, WASHINGTON NAME: MADDING, LINDA LOC: I-SUR-2322

34/29/02DATE: 4/29/0231/1/9831/1/9831/1/9831/1/9831/1/9831/1/9831/1/98 HOSP. NO: 241666
3PHYS: MDTAMARA J. SLEETER, M.D. TAMARA J. SLEETER, M.D.

PREOPERATIVE DIAGNOSIS: Vaginal vault prolapse.

POSTOPERATIVE DIAGNOSIS: Same.

OPERATION: ANTERIOR-POSTERIOR REPAIR, SACROSPINOUS FIXATION, AND PLACEMENT OF TENSION-FREE VAGINAL TAPE.

SURGEON: TAMARA J. SLEETER, M.D.

ASSISTANT: JULIE KAMOROW, M.D.
ANESTHESIA: General.
ANESTHESIOLOGIST:

OPERATIVE INDICATIONS: The patient is a REDAC year-old multigravida with a prior hysterectomy. She has noted progressive vaginal vault prolapse with cystocele, rectocele, and difficulty voiding. She also has difficulty retaining urine when she coughs or sneezes.

OPERATIVE FINDINGS: A somewhat shortened vaginal vault with a prolapse of cuff through the introitus and a second-degree cystocele and rectocele. There was obvious stress urinary incontinence.

OPERATIVE PROCEDURE: After the induction of general anesthesia, the patient was prepped and draped in the usual fashion. The junction of the anterior and posterior vaginal cuffs was identified and placed on a tenaculum, which promptly brought it down to the introitus.

The anterior vaginal wall was opened just above this from approximately 1 cm from the apex of the cuff to up under the urethra. The vaginal wall was widely dissected in a diamond-shaped fashion. When it was felt the dissection was adequate, the bladder pillars were exposed. The vaginal mucosa was trimmed in a way to elongate the vagina anteriorly compared to what it had been. A sponge was then placed in this area and attention was turned to the posterior vaginal vault.

The peritoneum was opened transversely with the scissors, and Metzenbaum scissors were used to dissect in the midline up towards the vaginal cuff. There was considerable scarring in the perineal area, which took some time to open and resect. It was felt that the rectum would close; it was quite thin near the perineum, but the rectum was not perforated.

After the posterior vault had been opened up to within 1 cm of the vaginal cuff, the posterior vaginal epithelium was dissected off the rectal area and out to the pelvic sidewalls and levator muscles. In this fashion, the spinous process was exposed on the patient's right and the rectum and descending sigmoid were reflected off of it.

With adequate exposure, the Miya hook was placed through this and the appropriate placement with the Gore-Tex suture loaded. The suture was retrieved and left tagged for future reference. The posterior vaginal mucosa was then trimmed and a check made for adequate vaginal diameter. It was felt to be good with lengthening posteriorly as well as anteriorly.

Attention was then turned to the anterior vaginal wall, and plication sutures of #0 Vicryl were used to reduce the cystocele. The anterior vaginal wall was then closed with 2-0 chromic until approximately 1.5 cm away from the end of dissection, leaving a pocket underneath the urethra for placement of the tape later in the procedure.

Attention was then turned to the posterior vaginal vault. The Gore-Tex sutures that had been retrieved were then placed into the cuff, one toward the midline and one more toward the right. After a check for placement, these were left tagged.

The posterior levator muscles were then approximated with two stitches using #0 Vicryl, with reduction of the rectocele. An additional supporting suture was placed in the area where thinning had been noted at the perineum. The posterior vaginal wall was then partly repaired with 2-0 chromic, and then the Gore-Tex sutures were tied down with nice approximation of the cuff to the sacrospinous area. These sutures were trimmed and felt to be very nicely placed.

The posterior repair was then completed with placement of an additional Vicryl stitch near the perineum and repair of the vaginal wall with 2-0 chromic out to the perineum. All these areas were dry.

Attention was then turned to the urethra, and the bladder was emptied. A stiffener was placed in the Foley catheter and the urethra displaced, using a Foley to displace both the urethra and the bladder. The bladder was directed to the patient's left, and the first of the needles for tension-free vaginal tape (TFV) was then passed through the remaining opening underneath the urethra and the vaginal mucosa and directed out just lateral to the midline of the pubic bone. The back wall of the symphysis was hugged, and the needle was guided by feel up toward an abdominal finger. The skin was penetrated and the needle left in place.

The cystoscope was passed, finding that the bladder wall was intact and there was no evidence of tape inside the urethra or bladder structures. The needle was then pulled through and a similar procedure carried out on the opposite side. Before the tape was tightened, a thorough look around at the bladder was achieved without evidence of trauma to the bladder or urethra. The cystoscope was then removed and the bladder left full of water. Using a crede maneuver, it became obvious just how far the tape should be tightened, and a Kelly clamp was used to support the tape underneath the urethra to prevent over-tightening.

The needles were removed and the sheath removed from the tape with excellent results. It was felt this tape was nicely placed without over-correction but with adequate support for this patient's needs for the future.

The anterior vaginal wall was then completely closed using the suture that had been left behind of 2-0 chromic with excellent results. A pack was placed and a Foley was placed in the bladder with return of clear urine. The patient was then sent to Recovery in stable condition.

ESTIMATED BLOOD LOSS: 350 cc.
SPONGE AND NEEDLE COUNTS: Correct.

ID**TJS(4341):DSC\88009/1222843
D: 04/29/02 13:59
T: 04/28/02 09:32

DICTATED AND AUTHENTICATED BY: TAMARA J. SLEETER, M.D.

cc: JULIE KAMOROW, M.D.

~mrn: REDACTED
~acc: REDACTED
~patient name: MADDING, LINDA
~document type: OP
~responsible physician: TAMARA J. SLEETER, M.D.
~responsible physician id: 4341
~referring physician:
~referring physician id:
~date/time of admission:
~date/time of dictation: 04/29/02 13:59
~date/time of procedure: 4/29/02
~date/time of transcription: 04/30/2002 12:39
~document id number: 665259

3(CONTINUED)

REPORT OF OPERATION

List manufacturer item, description, lot# implant site, size and quantity

Product Traceability Label
TVT DEVICE 810041
STERILE EO P15505
Rx only 925515
GYNECARE

DO NOT WRITE IN THIS SPACE

SURGPLABEL PLW
INPATIENT REDACTED N
F REDACTED Z
MADDING, LINDA J
REDACTED SLEETER, T

042902

86 8005 0 (8 97) VALLEY MEDICAL CENTER SURGICAL IMPLANT RECORD Page 1 of 1

MEDICAL RECORDS COPY

EXHIBIT 8

FOCUS PROGRESS NOTES

Date	Time	Focus	Focus D=Data A=Action R=Response Progress Notes
4/29/02		POSTOPERATIVE NOTE	
		1. Primary Surgeon / Asst	Sleeter / Komarov
		2. Findings	vaginal vault prolapse c̄ SUI
		3. Technical Proc Used	1) A&P repair 2) sacrospinous fixation 3) placement of tension free vaginal tape
		4. Specimens	none
		5. Postop Diagnosis	Vaginal vault prolapse
		6. Est. Blood Loss	350 cc
			dict 4/29/02
			[signature] MD
4/30/02	0945	PD #1	Stable appetite returning
			abd soft
			will try to DC foley today
			Amb satisfactory progress
			Rx because of extensive pelvic surgery will
			observe until tomorrow
			[signature] MD
4/30/02	1100		pt. c̄ c/o not voiding - has tried every-
			thing Abd distended very uncomfortable
	1115		cath'd for 1000 mm. return. c̄
			500 later Much relief —— [signature] RN

Valley Medical Center
Renton Wa 98055

EXHIBIT
16
Sleeter
9-7-16
PENGAD 800-631-6989

INPATIENT REDACTED PLW
REDACTED Z SUR
MADDING, LINDA J.
REDACTED SLEETER, T.

FOCUS PROGRESS NOTES

FOCUS PROGRESS NOTES - CONTINUED

Date	Time	Focus	Focus D=Data A=Action R=Response Progress Notes
4-30-03			Discharged home with phone call
			home on pain meds to include vicodin
			home with foley plus leg bag
			see next week for foley removal andfollow-up
			Tamara J. sleeter, M.D.
			Signed: TAMARA J SLEETER 05/21/2002 08:40 PDT